Providing services to meet need rather than by specialty could mean patients receive better services and would be a more efficient use of NHS resources.

Improving services for long-term conditions

In this article...

- Why long-term conditions services need to be redesigned
- How earlier intervention can reduce patient morbidity
- Why focusing on need, not specialty, will bring results

Author: Gilmour Frew is director, NHS Improvement.


Providing services by personal need, rather than by specialty, could improve services and make better use of NHS resources. NHS Improvement’s long-term conditions pathway recognises nurses’ key role in planning care and responding to need, and offers four key steps for better care.

One of the biggest issues facing healthcare providers as they strive for service improvement is that of managing long-term conditions. Just over 15 million people in England have a long-term condition, such as diabetes, heart disease, dementia, and chronic obstructive pulmonary disease (COPD). These patients are intensive users of healthcare services and, as the population ages, the costs of care for these conditions will rise.

Economic necessity, the emphasis on quality of life, and the drive toward more patient-centred services have influenced change in the national approach to managing long-term conditions. In 2005 the Department of Health’s National Service Framework for Long-term Conditions identified the need for a generic model for management. Yet, while progress has been made in improving services and care, significant barriers remain.

How do you integrate health, social, and voluntary services when there are conflicting financial implications? How do you encourage service integration in a system measured and funded by activity rather than outcome? Who ultimately takes responsibility for managing the care of patients presenting with multiple conditions over time? How do you coordinate services with conflicting priorities?

A new approach

NHS Improvement has been working on a new approach to managing long-term conditions – one that takes these issues into account. This has the potential to provide an evidence base for achievable efficiencies that can stimulate radical service change.

This approach recognises that nurses – be they in community, acute, primary or mental health settings – are central to effective management as they are essential in planning care and responding to need as illnesses progress. It provides a pathway for managing long-term conditions, which is based on four key stages where patients and carers want improvements:

» Finding out;
» Living with;
» When things go wrong;
» Towards the end.

Finding out

The “finding-out” stage of the pathway involves testing for a condition, with rapid access to services to enable an earlier diagnosis and optimal treatment.

Living with

At the “living-with” stage, the delivery of a detailed and comprehensive care plan is essential to coordinate care, to support and treat the patient and, at the same time, to provide information that can help the patient to manage the condition more effectively. Monitoring patients and making best use of telemedicine will help to sustain recovery and get them back on to their feet.

Keywords: Long-term conditions/Service redesign/Joint working

This article has been double-blind peer reviewed.

In Gwent, an integrated service for older people who are frail has improved care.

In other areas, patients who have cancer and chronic obstructive pulmonary disease are supported in line with the pathway.

Patients with long-term conditions need support throughout the disease trajectory.
When things go wrong
The availability of care seven days a week, in line with patient needs, is essential at the “when-things-go-wrong” stage if timely access to healthcare is to be provided. Readmissions can be avoided by giving patients advice that will help them better understand and manage their symptoms, and giving nurses the skills they need to recognise when to seek support early rather than waiting until a patient reaches crisis point.

Towards the end
At the “towards-the-end” stage, the emphasis is on supportive and palliative care. Patients are helped to understand the progress of their condition and involved in planning care in advance, in accordance with their own wishes.

Basis of each stage
The provision of timely information, detailed care planning and review, engagement with patients and carers, and the seamless transfer of care across pathways and organisations are the foundations for effective delivery of each stage.

Nurses in all environments can drive service transformation by adopting the pathway’s core principles. These are:
- Providing effective communication in care planning and review;
- Putting the patient at the centre of everything;
- Empowering patients to manage conditions through information and education; and
- Taking timely action to ensure referral to the right person or agency when problems occur.

In the evolving commissioning environment in particular, there is a growing need to look at the management of long-term conditions in terms of local populations across rural and urban communities in the same area, and by personal need (for example, in terms of those who are frail or older and frail), rather than by conditions and their associated specialties. Specialist services will be needed at times but, to ensure optimum outcome, the specialty should operate within an integrated system of healthcare and social support.

A frailty programme in Gwent is an outstanding example of this approach (Box 1).

Improvement projects
NHS Improvement-supported long-term conditions projects include support for people with cancer provided by the Ipswich Hospital Trust, and a collaboration providing end-of-life care in Solihull.

Guidance for people with cancer
Moving On, a programme established by Ipswich Hospital Trust, provides peer support, education and guidance to patients who have cancer after a holistic assessment when their treatment has ended.

For two hours a week for four weeks, patients who attend the hospital’s Cancer Information Centre receive guidance from its clinical nurse specialists. This covers symptom management, emotional support, advice and information on all types of cancer, as well as topics that may affect a return to normal life or the quality of life. These typically cover goal setting, diet, physical activity, fatigue, relationship and sexual issues, returning to work, financial issues, anxieties and fears. Patients are involved in the development of their own care plans and any support needed is identified and arranged.

Palliative care for COPD
At the former Solihull Care Trust, a collaboration between GPs has enabled patients with COPD to benefit from a more holistic approach to palliative care.

A project team working in 12 of the 31 local GP practices conducted a baseline assessment of end-of-life care for patients with COPD. Two GP COPD champions were appointed to work with the practices, helping them to identify patients eligible for further support services. Communication with the community respiratory team and the end-of-life provision in hospitals improved, as did relationships between patients, carers and providers overall.

A whole-community approach
Getting this model for long-term conditions right requires setting up a “virtual” service in which the organisations involved support patients by collectively ensuring the most appropriate person provides the most appropriate care at the right time. Patients can “pull” services to them, and do not have to wait until what could prove to be the wrong time.

This model could bring us closer to bridging the gap between future need and financial imperative, thereby addressing issues raised by patients, carers and nursing teams responsible for ongoing care and wellbeing. It could also provide an opportunity to address the bureaucratic separation of services and conflicting financial incentives that can hinder achieving caring professionals’ common goals and causes.

Reference

Useful websites
Gwent Frailty Programme www.gwentfrailty.torfaen.gov.uk

BOX 1. GWENT FRAILTY PROGRAMME

Healthcare and social care services in Gwent have been integrated within two management teams for care of older people who are frail. These teams provide 80% general and 20% specialist care. GPs, district nurses, acute services, social services and ambulance services work together. Their realignment within the management teams refoeses activity on the patient, not the process.

As Gwent has a single point of access to these services for older people who are frail, patients are assured of a direct, straightforward route to appropriate care, irrespective of age, or medical or social considerations.

Rapid assessment, reablement and emergency care is delivered in the patient’s home. Community resources teams provide three levels of support: rapid response (within four hours); reablement (within 24 hours); and hospital-at-home services for up to 14 days. Patients have access to services 24 hours a day, seven days a week, 365 days a year. Teams can avert crisis and provide better outcomes as a result.

The changes have reduced acute hospital admissions and lengths of stay. Health and social care assessments can be undertaken quickly, problems are resolved more quickly and fewer complex care packages are needed.

In setting up the model, the multidisciplinary health and social care teams established that:
- 50% of patients in community hospital beds did not need to be there;
- People could be treated holistically rather than being defined by a single illness;
- People could stay at home for longer;
- 60% of patients were able to leave the care of the community resource team after eight weeks of support with no ongoing care required.